FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016964

Facility Name: Bohannon Nursing Home

Address: 1201 North Alton (Number) Lebanon (City) 62254 (Zip Code)

County: St. Clair

Telephone Number: (618)537-4401 **Fax #** (618)537-4447

IDPA ID Number: 37-0708824-001

Date of Initial License for Current Owners: 04/06/1950

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Michael J. Hund **Telephone Number:** (618)566-2341

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Ken Bohannon
(Title) President

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Michael J. Hund, Partner
(Firm Name & Address) Boyce, Hund & Associates, 42 West Main St. Mascoutah, IL 62258
(Telephone) (618)566-2341 Fax # (618)566-4220

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	101	Skilled (SNF)	101	36,865	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,865	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	14,293	12,344	261	26,898	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,293	12,344	261	26,898	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.96%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 04/12/1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 9 and days of care provided 261

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	136,709	7,572	5,744	150,025		150,025		150,025			1
2	Food Purchase		109,892		109,892		109,892	(648)	109,244			2
3	Housekeeping	97,977	12,968		110,945		110,945		110,945			3
4	Laundry	29,363	7,490		36,853		36,853		36,853			4
5	Heat and Other Utilities			64,102	64,102		64,102		64,102			5
6	Maintenance	12,246	5,356	14,974	32,576		32,576		32,576			6
7	Other (specify):*											7
8	**TOTAL General Services**	276,295	143,278	84,820	504,393		504,393	(648)	503,745			8
	B. Health Care and Programs											
9	Medical Director			3,300	3,300		3,300		3,300			9
10	Nursing and Medical Records	774,048	35,997	46,897	856,942		856,942	(6,344)	850,598			10
10a	Therapy	24,048	13	150	24,211		24,211	(5,933)	18,278			10a
11	Activities	25,867	2,142	534	28,543		28,543		28,543			11
12	Social Services	19,543		2,335	21,878		21,878		21,878			12
13	Nurse Aide Training	10,700	359	450	11,509		11,509		11,509			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	854,206	38,511	53,666	946,383		946,383	(12,277)	934,106			16
	C. General Administration											
17	Administrative	80,597			80,597		80,597		80,597			17
18	Directors Fees											18
19	Professional Services			94,683	94,683		94,683	(42,000)	52,683			19
20	Dues, Fees, Subscriptions & Promotions			11,780	11,780		11,780	(2,526)	9,254			20
21	Clerical & General Office Expenses	34,716	5,967	7,505	48,188		48,188	(339)	47,849			21
22	Employee Benefits & Payroll Taxes			143,912	143,912		143,912	(1,277)	142,635			22
23	Inservice Training & Education			1,075	1,075		1,075		1,075			23
24	Travel and Seminar			2,901	2,901		2,901	(1,982)	919			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			53,803	53,803		53,803		53,803			26
27	Other (specify):*			24,917	24,917		24,917	(24,917)				27
28	**TOTAL General Administration**	115,313	5,967	340,576	461,856		461,856	(73,041)	388,815			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,245,814	187,756	479,062	1,912,632		1,912,632	(85,966)	1,826,666			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bohannon Nursing Home #0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			83,611	83,611		83,611	(27,790)	55,821			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,826	15,826		15,826	(15,826)				32
33	Real Estate Taxes			38,700	38,700		38,700		38,700			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			5,845	5,845		5,845		5,845			35
36	Other (specify):*											36
37	**TOTAL Ownership**			143,982	143,982		143,982	(43,616)	100,366			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			23,817	23,817		23,817		23,817			39
40	Barber and Beauty Shops			6,439	6,439		6,439	(6,095)	344			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,297	55,297		55,297		55,297			42
43	Other (specify):*			192	192		192	(192)				43
44	**TOTAL Special Cost Centers**			85,745	85,745		85,745	(6,287)	79,458			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,245,814	187,756	708,789	2,142,359		2,142,359	(135,869)	2,006,490			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(27,790)	30		9
10	Interest and Other Investment Income	(15,826)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(648)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(3,297)	27		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(192)	43		24
25	Fund Raising, Advertising and Promotional	(2,176)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(85,940)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (135,869)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (135,869)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Bohannon Nursing Home

ID# 0016964

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Beauty Shop Revenue	$ (6,095)	40	1
2	Airplane	(1,620)	27	2
3	Non-Care Related Travel	(1,982)	24	3
4	Bank Charges	(339)	21	4
5	Subscriptions, Dues	(350)	20	5
6	Employee Lawsuit Settlement	(20,000)	27	6
7	Employee Meals	(577)	22	7
8	Employee Gifts	(700)	22	8
9	Patient Medical Supply Revenue	(6,344)	10	9
10	Therapy Revenue	(5,933)	10a	10
11	Marketing	(42,000)	19	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(85,940)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bohannon Nursing Home **#** 0016964 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(648)	0	0	0	0	0	0	0	0	0	0	(648)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(648)	0	0	0	0	0	0	0	0	0	0	(648)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(6,344)	0	0	0	0	0	0	0	0	0	0	(6,344)	10
10a	Therapy	(5,933)	0	0	0	0	0	0	0	0	0	0	(5,933)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(12,277)	0	0	0	0	0	0	0	0	0	0	(12,277)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(42,000)	0	0	0	0	0	0	0	0	0	0	(42,000)	19
20	Fees, Subscriptions & Promotions	(2,526)	0	0	0	0	0	0	0	0	0	0	(2,526)	20
21	Clerical & General Office Expenses	(339)	0	0	0	0	0	0	0	0	0	0	(339)	21
22	Employee Benefits & Payroll Taxes	(1,277)	0	0	0	0	0	0	0	0	0	0	(1,277)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,982)	0	0	0	0	0	0	0	0	0	0	(1,982)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(24,917)	0	0	0	0	0	0	0	0	0	0	(24,917)	27
28	**TOTAL General Administration**	(73,041)	0	0	0	0	0	0	0	0	0	0	(73,041)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(85,966)	0	0	0	0	0	0	0	0	0	0	(85,966)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Bohannon Nursing Home** **#** **0016964** **Report Period Beginning:** **01/01/2002** **Ending:** **12/31/2002**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(27,790)	0	0	0	0	0	0	0	0	0	0	(27,790)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,826)	0	0	0	0	0	0	0	0	0	0	(15,826)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(43,616)	0	0	0	0	0	0	0	0	0	0	(43,616)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(6,095)	0	0	0	0	0	0	0	0	0	0	(6,095)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(192)	0	0	0	0	0	0	0	0	0	0	(192)	43
44	**TOTAL Special Cost Centers**	(6,287)	0	0	0	0	0	0	0	0	0	0	(6,287)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(135,869)	0	0	0	0	0	0	0	0	0	0	(135,869)	45

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Ken Bohannon	100.00%	None				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Ken Bohannon	President	Asst. Administrato	100.00		24	60.00	Salary	$ 30,462	Ln 17, Col 1	1
2	Lee Bohannon-Smith	None	Administrator	0.00		40	100.00	Salary	50,135	Ln 17, Col 1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 80,597		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Not Applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Small Business Admin.		X	Addition Construction	$2,813.00	11/12/86	$ 332,000	$ 109,522	11/12/06	0.0800	$ 10,333	1
2	Bank of O' Fallon		X	Refinance (Construction)	$824.52	02/28/02	80,170	75,746	01/31/05	0.0700	5,253	2
3												3
4												4
5												5
	Working Capital											
6	First Insurance Funding		X	Liability Insurance	$3,483.00	06/01/01	30,330		03/01/02	0.0800	240	6
7												7
8												8
9	TOTAL Facility Related				$7,120.52		$ 442,500	$ 185,268			$ 15,826	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 442,500	$ 185,268			$ 15,826	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	37,564	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	38,132	2
3. Under or (over) accrual (line 2 minus line 1).	$	568	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	38,132	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	38,700	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	37,342	8
	1998	35,789	9
	1999	36,810	10
	2000	37,564	11
	2001	38,132	12

Line 2 - Payment applies to calendar year 2001

Line 4 - Accrual for 2002 is the amount of real estate taxes paid in 2002 for calendar year 2001.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bohannon Nursing Home COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0016964

CONTACT PERSON REGARDING THIS REPORT Michael J. Hund

TELEPHONE (618) 566-2341 FAX #: (618) 566-4220

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-18.0-300-019	Facility	$ 36,513.00	$ 36,513.00
2.	05-18.0-300-018	Facility	$ 651.00	$ 651.00
3.	05-18.0-308-010	Vacant lot across the street	$ 576.00	$
4.	05-18.0-309-001	Vacant lot across the street	$ 392.00	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 38,132.00	$ 37,164.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,919 B. General Construction Type: Exterior Brick Frame Concrete & Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	174,240	1972	$ 10,000	1
2					2
3	TOTALS	174,240		$ 10,000	3

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	51		1972	1972	$ 514,667	$ 12,867	40	$ 12,867	$	$ 386,000	4
5	50		1986	1986	705,125	36,395	40	17,628	(18,767)	289,395	5
6											6
7											7
8											8
	Improvement Type**										
9	Building Equipment			1972	67,551		10			67,551	9
10	Heating System, Air Conditioner			1978	18,296		15			18,296	10
11	Fire Alarm			1980	3,770		25			3,770	11
12	Fan System			1982	1,388		20	64	64	1,388	12
13	Roof			1983	38,993		25	1,560	1,560	30,935	13
14	Shed & Alarm			1983	7,672		20	384	384	7,331	14
15	Gas Line			1984	694		30	23	23	438	15
16	Heat Pumps			1984	11,560		15			11,560	16
17	Chart System, Windows, Doors			1984	3,847		20	192	192	3,481	17
18	Air Conditioners			1985	1,524		8			1,524	18
19	Water Heaters			1985	3,106		15			3,106	19
20	Sprinkler System			1986	39,807	2,095	25	1,592	(503)	26,140	20
21	Storage Trailer			1986	1,806		20	90	90	1,535	21
22	Water Heater, Nurse Call			1986	2,025		15			2,025	22
23	Alarm, Extinguisher, Phones			1986	859		10			859	23
24	Water Heater			1990	2,185		15	146	146	1,833	24
25	Water Heater			1991	2,034		15	136	136	1,503	25
26	Phone, Heater Unit			1992	1,799		10	125	125	1,799	26
27	Air Conditioner			1993	7,689		10	769	769	7,369	27
28	Air Conditioner			1995	2,385	120	10	238	118	1,709	28
29	Water Softener			1996	500	30	12	42	12	281	29
30	Front Circle Drive			1998	8,716	596	15	581	(15)	2,712	30
31	Parking Lot, Fuel Tank			1998	21,523	1,519	20	1,076	(443)	4,410	31
32	Water Softener			1998	2,764		12	230	230	998	32
33	Heating/Cooling Unit			1999	8,685	1,096	10	869	(227)	2,742	33
34	Roof			2000	15,823	1,353	20	791	(562)	1,912	34
35	Water Heaters			2000	5,810	1,016	15	387	(629)	1,065	35
36	Portable Aspirator, Phone System			2001	3,924		10	392	392	654	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Windows	2001	$ 7,905	$ 781	40	$ 198	$ (583)	$ 231	37
38	Trash Compactor	2002	8,462	8,462	10	776	(7,686)	776	38
39	Lift Truck	2002	782	313	10	65	(248)	65	39
40	Door Alarm	2002	2,242	2,242	10	75	(2,167)	75	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,525,918	$ 68,885		$ 41,296	$ (27,589)	$ 885,468	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 184,372	$ 10,536	$ 14,374	$ 3,838		$ 78,581	71
72	Current Year Purchases	4,190	4,190	151	(4,039)		151	72
73	Fully Depreciated Assets	143,917					155,553	73
74								74
75	TOTALS	$ 332,479	$ 14,726	$ 14,525	$ (201)		$ 234,285	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,868,397	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 83,611	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 55,821	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (27,790)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,119,753	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	25% Plane & Radio 1982	$ 6,574	$	$ 6,574	86
87	25% Plane Engine 1988	3,394		3,394	87
88	25% Storm Scope 1986	2,347		2,347	88
89	Pickup Truck 1979	8,743		8,072	89
90					90
91	TOTALS	$ 21,058	$	$ 20,387	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 5,845 Description: Copier (4913) + Computer (932)
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 89

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 50

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		48	311		359
3	Classroom Wages	(a)				
4	Clinical Wages	(b)		4,875		4,875
5	In-House Trainer Wages	(c)		5,825		5,825
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			450		450
9	TOTALS		$ 48	$ 11,461	$	$ 11,509
10	SUM OF line 9, col. 1 and 2	(e)	$ 11,509			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	13
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	15

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Line 39, Col 3	hrs	$	75	$ 4,631	$	75	$ 4,631	1
2	Licensed Speech and Language Development Therapist	Line 39, Col 3	hrs		33	1,887		33	1,887	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 39, Col 3	hrs		129	10,655		129	10,655	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 39, Col 3	# of prescrpts				6,277		6,277	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-Ray			367					367	13
14	TOTAL			$ 367	237	$ 17,173	$ 6,277	237	$ 23,817	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 440,386	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	425,011		3
4	Supply Inventory (priced at)	10,124		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,964		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): A/R Employees	1,915		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 894,400	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	243,913		12
13	Land	10,000		13
14	Buildings, at Historical Cost	1,219,792		14
15	Leasehold Improvements, at Historical Cost	306,126		15
16	Equipment, at Historical Cost	353,537		16
17	Accumulated Depreciation (book methods)	(1,585,031)		17
18	Deferred Charges	3,039		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	31,390		21
22	Other Long-Term Assets (specify):	10,100		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 592,866	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,487,266	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 40,714	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	64,318		30
31	Accrued Taxes Payable (excluding real estate taxes)	557		31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,132		32
33	Accrued Interest Payable	761		33
34	Deferred Compensation	4,403		34
35	Federal and State Income Taxes	800		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 149,685	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	185,268		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 185,268	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 334,953	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,152,313	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,487,266	$	48

***(See instructions.)**

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,164,524	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,164,524	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	49,639	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(61,850)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (12,211)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,152,313	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,141,767	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,141,767	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	5,933	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 5,933	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	8,086	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,095	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 14,181	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30,734	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,734	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Commissions	182	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 182	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,192,797	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	504,393	31
32	Health Care	946,383	32
33	General Administration	461,856	33
	B. Capital Expense		
34	Ownership	143,982	34
	C. Ancillary Expense		
35	Special Cost Centers	30,448	35
36	Provider Participation Fee	55,297	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,142,359	40
41	**Income before Income Taxes (line 30 minus line 40)****	50,438	41
42	**Income Taxes**	(799)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 49,639	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,856	2,080	$ 45,026	$ 21.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,652	4,701	88,235	18.77	3
4	Licensed Practical Nurses	12,121	12,882	203,219	15.78	4
5	Nurse Aides & Orderlies	45,399	45,950	429,360	9.34	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,837	2,046	24,048	11.75	8
9	Activity Director	1,946	2,080	20,158	9.69	9
10	Activity Assistants	897	897	5,709	6.36	10
11	Social Service Workers	1,582	1,686	19,543	11.59	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,030	23,654	11.65	13
14	Head Cook	4,856	5,271	42,914	8.14	14
15	Cook Helpers/Assistants	9,404	9,935	70,141	7.06	15
16	Dishwashers					16
17	Maintenance Workers	818	818	12,246	14.97	17
18	Housekeepers	13,088	13,522	97,977	7.25	18
19	Laundry	4,110	4,385	29,363	6.70	19
20	Administrator	1,784	2,080	50,135	24.10	20
21	Assistant Administrator	1,248	1,248	30,462	24.41	21
22	Other Administrative					22
23	Office Manager	1,859	2,080	23,890	11.49	23
24	Clerical	1,133	1,133	10,826	9.56	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,774	2,013	18,908	9.39	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	112,332	116,837	$ 1,245,814 *	$ 10.66	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 5,744	Ln 1, Col 3	35
36	Medical Director	48	3,300	Ln 9, Col 3	36
37	Medical Records Consultant	4	420	Ln 10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	808	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	150	Ln 10a, Col 3	42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	534	Ln 11, Col 3	44
45	Social Service Consultant	24	2,335	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	246	$ 13,291		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	578	21,681	Ln 10, Col 3	51
52	Nurse Aides	1,246	21,962	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	1,824	$ 43,643		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ken Bohannon	Asst. Administrator	100	$ 30,462
Lee Bohannon Smith	Administrator	0	50,135
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 80,597

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll	$ 6,643
Boyce, Hund & Assoc.	Accounting	13,955
MES of Illinois	Purchasing	51
Altschuler, Melvoin, Glasser	Accounting	2,306
American Express	Accounting	65
Ron Harvey	Marketing	42,000
Stratton, Giganti, Stone	Legal	29,663
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 94,683

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,757
Unemployment Compensation Insurance	11,735
FICA Taxes	92,263
Employee Health Insurance	
Employee Meals	577
Illinois Municipal Retirement Fund (IMRF)*	
EE Gifts	700
Retirement Plan Expense	8,880
Less: EE Meals	(577)
EE Gifts	(700)
TOTAL (agree to Schedule V, line 22, col.8)	$ 142,635

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,111
Health Care Worker Background Check	64
(Indicate # of checks performed 5)	
HCFA Lab Program	150
IHCA Dues	225
Sam's Wholesale Club	55
NFIB Dues	350
INHAA	150
Attached Schedule	2,325
Less: Public Relations Expense	( )
Non-allowable advertising	(2,176)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,254

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,341
Seminar Expense	560
Administrative Travel	(1,982)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 919

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Bohannon Nursing Home # 0016964 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Bohannon Nursing Home # 0016964 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA = 225**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,297**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.